

Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as a Respiratory Care Practitioner. It is strongly suggested that you read the Regulations prior to filling out the application, and then examine the directions entitled "**STEPS TO LICENSURE**" to see which forms are appropriate for you.

Please note the following:

- (a) Applications not completed in their entirety will be returned, minus the application fee, which is non-refundable.
- (b) The photograph must be a "passport photo."
- (c) The name on the application must match the name on the driver's license or Social Security Card. We will not accept nicknames, abbreviations, or alterations.
- (d) All fees are to be made payable to the Mississippi State Department of Health.

If you have any questions regarding the above, please contact our office as follows:

MISSISSIPPI STATE DEPARTMENT OF HEALTH  
PROFESSIONAL LICENSURE-RESPIRATORY CARE  
P.O. BOX 1700  
JACKSON, MS 39215-1700  
(601) 576-7260

**Please be advised that it is illegal to practice Respiratory Care in Mississippi without being licensed or exempted by statute or regulations. Individuals engaging in such practices, or employing non-licensed practitioners, will be subject to criminal and/or civil penalties.**

Sincerely,

David Kweller  
Health Facilities Surveyor II

DK/bj  
Enclosure

**TO: Applicants for Temporary Permit**

FROM: David Kwellner  
Health Facilities Surveyor II

RE: Verification of Professional Education

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Beginning immediately, the Verification of Professional Education forms, for those students who have not yet graduated, must be completed by the program director. The only Verification of Education forms that will be accepted from the registrar's office are for those individuals who have received their certificate of completion and/or degree.

# **STEPS TO LICENSURE RESPIRATORY CARE PRACTITIONER**

Enclosed is an application packet for a respiratory care practitioner. Two types of licences are currently issued in Mississippi: Regular and Temporary Permit. The requirements for each are as follows:

**1. Regular**

- a. Completed, notarized application.
- b. Copy of driver's license or social security card.
- c. Passport style photo
- d. Application fee - \$75.00 (non-refundable).
- e. Copy of NBRC card or certificate.
- f. Copies of all licensure or registrations from other states.
- g. Verification of NBRC credential (Form 633)

**2. Temporary Permit (a 6 month license - renewal once for 6 months issued up to one year after graduation from an approved school) :**

- a. Completed, notarized application.
- b. Copy of driver's license or social security card.
- c. Passport style photo
- d. Application fee - \$50.00 (non-refundable).
- e. Verification of Education form showing proof of graduation and eligibility to sit for the NBRC examination.
- f. Copies of all licensure or registrations from other states.

**NOTE: Application for temporary permit can be submitted 30 days prior to graduation.**

All requirements must be on file and satisfactory to this office before a license may be issued.

Respiratory Care  
NBRC, Inc.  
**Credential Verification for Mississippi**

**To Applicant:** Complete Section I below and submit it along with the required \$3.00 fee for active members and \$15 fee for inactive members to: National Board for Resp. Care, Inc.  
8310 Nieman Road  
Lenexa, Kansas 66214

**To NBRC:** Complete Section II below and return completed form to: Mississippi State Department of Health  
Professional Licensure-Respiratory Care  
P. O. Box 1700  
Jackson, Mississippi 39215-1700

### Section I

I am applying for state licensure in Mississippi, and I am requesting the NBRC verify my respiratory therapy credentials directly to the Mississippi State Department of Health, Branch of Professional Licensure.

I hold the following NBRC Credentials: ☐ CRTT ☐ RRT

Print name under which you were credentialed (*last, first, middle initial*)

Applicant full name (please print) (*last, first, middle initial*)

Social Security Number

Signature

Date

### Section II (*for NBRC use only*)

The above named person has achieved the minimum passing score required for successful completion of an examination and earned the following NBRC credentials:

**Credentials**

**Date Credentialed**

☐ CRTT (number \_\_\_\_\_)

☐ RRT (number \_\_\_\_\_)

Signature

Date

Not valid unless embossed with NBRC seal (*in space below*)



Respiratory Care

# Verification Of Professional Education For Licensure

**Instruction To Applicant:**

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the Institution where you obtained your degree in Respiratory Care.

<i>Date</i>			
<i>Name (Last, First, Middle Initial)</i>	<i>Maiden Name or Given Surname</i>		
<i>Address (Street, City, State and Zip Code)</i>	<i>Phone No.</i>  (       )	<i>Home</i>  (       )	<i>Work</i>  (       )
<i>Social Security Number</i>	<i>Date of Graduation</i>		

**Waiver For The Release Of Information:**

I am applying for licensure as a Respiratory Care Practitioner in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Respiratory Care, should this information be requested at any time.

\_\_\_\_\_  
*Date*                      *Signed*

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**Instructions To Educational Institution:**

Upon completion of this form please send to: Mississippi State Department Of Health  
Professional Licensure - Respiratory Care  
P.O. Box 1700  
Jackson, MS 39215-1700

<i>Name of Institution</i>	<i>Location of Institution (City&amp;State)</i>
<i>Dates of Attendance (Month/Year)</i>  From:                      To:	<i>Total Number of Academic Years</i>
<i>Date Degree Conferred, or, Expected Date</i>	<i>Degree Conferred, or, to be Conferred</i>
<i>Program Name &amp; Curriculum Description</i>	

*Seal of the Institution*

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Telephone Number*                      *Date*



Respiratory Care  
**Application for Temporary Permit**

**Office Use**

Check No. \_\_\_\_\_

Amount \$ \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please type or print in ink)

1. Date: \_\_\_\_\_

2. Name: \_\_\_\_\_  
(Last) (First) (Middle)

3. Home Address: \_\_\_\_\_ 4. Telephone Number (\_\_\_\_) \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_  
(City) (State) (Zip Code) (County)

8. Social Security No. [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ] 9. Date of Birth: [ ][ ] - [ ][ ] - [ ][ ]

10. Race: \_\_\_\_\_ 11. Sex: Male ☐ Female ☐ 12. U.S. Citizen: No ☐ Yes ☐ 13. Legal Alien: No ☐ Yes ☐

14. Place of Employment: \_\_\_\_\_

15. Title of Position: \_\_\_\_\_ 16. Supervisor: \_\_\_\_\_

17. Employment Address: \_\_\_\_\_ 18. Telephone Number (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

19. Are there any criminal or civil suits pending against you? If yes, attach a full explanation. No ☐ Yes ☐

20. Are you now addicted to or have you ever excessively used alcohol, narcotics, barbiturates or habit forming drugs? If yes, attach a full explanation. No ☐ Yes ☐

21. Have you ever been convicted of any violations of law (except minor traffic violations)? If yes, attach a full explanation. No ☐ Yes ☐

22. a. Have you ever had a license or permit encumbered in any way? No ☐ Yes ☐

b. If yes, has the decree changed? Attach a full explanation. No ☐ Yes ☐

23. Have you ever been declared mentally incompetent by any court? If yes, attach an explanation. No ☐ Yes ☐

24. a. Are you currently a student in a JRCRTE approved Respiratory Care Education Program? No ☐ Yes ☐

b. Expected date of graduation \_\_\_\_\_.

25. a. Are you now, or have you ever been licensed in another state in the area of Respiratory Care? No ☐ Yes ☐

b. If yes, what state? (Attach a copy of license) \_\_\_\_\_



Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 20 \_\_\_\_\_.  
My commission expires\_\_\_\_\_.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Respiratory Care Practitioners and affirm that all conditions for licensure have been met and will be maintained.

\_\_\_\_\_  
(Notary Public)

\_\_\_\_\_  
(Applicant's Signature)

*Notary Seal*

*Copy of Social Security Card  
or  
Drivers License*

*Photo  
(only a Passport Photo  
will be accepted)*

Complete form, enclose fee and mail to: **Mississippi State Department of Health  
Professional Licensure: Respiratory Care  
P. O. Box 1700  
Jackson, Mississippi 39215-1700**



# Respiratory Care Application for Renewal of Temporary Permit

## Office Use

Check No. \_\_\_\_\_

Amount \$ \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(Please type or print in ink)

Check here if change in: Name ☐ Address ☐ Telephone ☐ Employment ☐

1. License Number \_\_\_\_\_ 2. Expiration Date \_\_\_\_\_

3. Date: \_\_\_\_\_ 4. Social Security No. \_\_\_\_\_

5. Name \_\_\_\_\_  
(Last) (First) (Middle)

6. Home Address: \_\_\_\_\_ 7. Telephone Number (\_\_\_\_) \_\_\_\_\_

8. \_\_\_\_\_ 9. \_\_\_\_\_ 10. \_\_\_\_\_  
(City) (State) (Zip Code) (County)

11. Place of Employment: \_\_\_\_\_

12. Employment Address: \_\_\_\_\_ 13. Telephone Number (\_\_\_\_) \_\_\_\_\_

14. \_\_\_\_\_ 15. \_\_\_\_\_ 16. \_\_\_\_\_  
(City) (State) (Zip Code) (County)

17. a. Are you a graduate of a JRCRTE approved respiratory care program? No ☐ Yes ☐

b. Date of graduation \_\_\_\_\_

18. a. Have you taken the NBRC, Inc. examination? No ☐ Yes ☐

b. If yes, give date and location \_\_\_\_\_

19. Set forth, in detail, the reasons why a regular license is not being applied for, and a temporary permit renewal is being requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 20 \_\_\_\_\_

My commission expires \_\_\_\_\_

\_\_\_\_\_  
(Notary Public)

I, the undersigned, do solemnly swear or affirm that I am the above applicant.  
I have read the above application and all statements contained therein or  
accompanying this application are true to the best of my knowledge and belief.

\_\_\_\_\_  
(Applicant's Signature)

*Notary Seal*

Complete form, enclose fee and mail to:

Mississippi State Department Of Health  
Professional Licensure: Respiratory Care  
P. O. Box 1700  
Jackson, Mississippi 39215-1700



Respiratory Care  
**Application for Licensure**

**Office Use**

Check No. \_\_\_\_\_

Amount \$ \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please type or print in ink)

1. Date: \_\_\_\_\_
2. Name: \_\_\_\_\_  
(Last) (First) (Middle)
3. Home Address: \_\_\_\_\_ 4. Telephone Number (\_\_\_\_) \_\_\_\_\_
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_  
(City) (State) (Zip Code) (County)
8. Social Security No.    -   -    9. Date of Birth:   -   -
10. Race: \_\_\_\_\_ 11. Sex: Male ☐ Female ☐ 12. U.S. Citizen: No ☐ Yes ☐ 13. Legal Alien: No ☐ Yes ☐
14. Place of Employment: \_\_\_\_\_
15. Title of Position: \_\_\_\_\_ 16. Supervisor: \_\_\_\_\_
17. Employment Address: \_\_\_\_\_ 18. Telephone Number (\_\_\_\_) \_\_\_\_\_
- \_\_\_\_\_  
(City) (State) (Zip Code) (County)
19. Are there any criminal or civil suits pending against you? If yes, attach a full explanation. No ☐ Yes ☐
20. Are you now addicted to or have you ever excessively used alcohol, narcotics, barbiturates or habit forming drugs? If yes attach a full explanation. No ☐ Yes ☐
21. Have you ever been convicted of any violations of law (except minor traffic violations)? If yes, attach a full explanation. No ☐ Yes ☐
22. a. Have you ever had a license or permit encumbered in any way? No ☐ Yes ☐  
b. If yes, has the decree changed? Attach a full explanation. No ☐ Yes ☐
23. Have you ever been declared mentally incompetent by any court? If yes, attach an explanation. No ☐ Yes ☐
24. a. Are you currently credentialed by the National Board for Respiratory Care, Inc.? No ☐ Yes ☐  
b. NBRC certification number: \_\_\_\_\_ (attach a copy of your certification)
25. Are you currently licensed in another state in the area of Respiratory Care? No ☐ Yes ☐  
b. If yes, what state? (Attach a copy of current license) \_\_\_\_\_



Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 19 \_\_\_\_\_.  
My commission expires \_\_\_\_\_.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Respiratory Care Practitioners and affirm that all conditions for licensure have been met and will be maintained.

\_\_\_\_\_  
(Notary Public)

\_\_\_\_\_  
(Applicant's Signature)

*Notary Seal*

*Copy of Social Security Card  
or  
Drivers License*

Complete form, enclose fee and mail to:

**Mississippi State Department of Health  
Professional Licensure: Respiratory Care  
P. O. Box 1700  
Jackson, Mississippi 39215-1700**

*Photo  
(only a Passport Photo  
will be accepted)*

